BONE DENSITY QUESTIONNAIRE

NAME: __________________________ DATE: __________________________

PHYSICIAN: __________________________ DOB: __________________________

1. Is there a chance you are pregnant? __________________________
2. Have you had a barium x-ray or nuclear medicine scan or injection of x-ray dye in the last 2 weeks? __________________________
3. Do you have metal in your spine or hips? __________________________
4. Have you ever broken (fractured) a bone as an adult? __________________________
5. Explain any fractures as an adult: (age it happened & how it occurred) __________________________
6. Have you ever been diagnosed with HYPERPARATHYROIDISM? __________________________

Do you take calcium pills (including TUMS) daily? __________________________
Do you take vitamin D daily? __________________________
Do you take multi-vitamin daily? __________________________ list type __________________________
Do you take hormones now? __________________________ list type __________________________
Do you take testosterone now? __________________________
Do you take Tamoxifen now? __________________________
Do you take Evista now? __________________________

Do you take any of these medicines now or have you in the past, please circle:

Etidronate (Didrolen/Didrocal) Alendronate (Fosamax) Risedronate (Actonel)
Intravenous Pamidronate (Aredia) Clodronate (Bonefos, Ostac) PTH (Forteo)
Calcitonin (Miacalcin nasal spray) Zoledronic Acid (Zometa) (Reclast) Ibandronate (Boniva)

List # of daily servings of calcium enriched foods/drinks per day (examples: dairy products, cheese, fortified orange juice, almonds, some leafy greens, etc.) __________________________

Has your: (MOTHER) (GRANDMOTHER) (SISTER) been diagnosed with a ----
(Hip Fracture) or (Osteoporosis) ---- Please circle __________________________

Do you currently receive or have you previously received any of the following: (if yes list how long)
1. medication for seizures or epilepsy __________________________
2. chemotherapy for cancer __________________________
3. medication for prostate cancer __________________________
4. medication to prevent organ transplant rejection __________________________
5. steroids for chronic asthma or arthritis __________________________
6. medication for thyroid problems __________________________

Do you have intestinal problems such as Crohn's Disease or Ulcerative Colitis? __________________________
Have you had renal kidney failure? __________________________ if yes, are you on dialysis? __________________________

Do you currently consume 3 or more alcoholic beverages per day? __________________________
Do you currently smoke __________________________ or have you smoked in the past? __________________________
Last menstrual cycle __________________________ or age/date of hysterectomy __________________________

Last Bone Density: (date & place) __________________________

HEIGHT: __________________________ WEIGHT: __________________________ TECH: __________________________

SIGNATURE: __________________________ I ATTEST THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE __________________________

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT DATE __________________________ TECHNOLOGIST __________________________

BHN - NW Bone Density Questionnaire (1/1)
REV 07/2019